Complete Summary

GUIDELINE TITLE

Treatment for stimulant use disorders.

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol (TIP) Series 33 Consensus Panel. Treatment for stimulant use disorders. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 33). [317 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Stimulant use disorders: cocaine and methamphetamine

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management
Treatment

CLINICAL SPECIALTY

Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To advance the understanding of treating the substance use disorders associated with the abuse of cocaine and methamphetamine.

TARGET POPULATION

Patients who abuse the following stimulants:

- Derivatives of the coca plant (cocaine hydrochloride and its freebase form, "crack")
- Synthetically produced amphetamines (illicitly produced methamphetamine and its smokable form, "ice")

This guideline does not address patients who abuse the following:

- Stimulants that are more widely used (e.g., caffeine) or that produce major health problems (e.g., nicotine).
- Methamphetamine analogs (e.g., "designer drugs" such as MDA [3,4-methylenedioxy-amphetamine] and MDMA [3,4-methylene-dioxymethamphetamine]).

INTERVENTIONS AND PRACTICES CONSIDERED

Treatment

1. Psychosocial treatment, including the use of treatment manuals, community reinforcement plus vouchers, contingency management, behavioral family/couples psychotherapy, "node-link mapping", network therapy, acupuncture, and therapeutic communities.
2. Relapse prevention and patient education.
3. Interventions to maximize treatment engagement.
4. Assessment procedures to enhance treatment engagement.
5. Strategies for initiating treatment, including schedule planning, incentives, creating a positive environment, remediation of withdrawal symptoms, crisis resolution.
6. Strategies for maintaining abstinence, including relapse prevention techniques, contingency management, avoidance strategies, role-playing, patient education, support systems, social and vocational counseling.

Management

1. Managing stimulant intoxication, including pharmacological intervention, when appropriate, with fast-acting benzodiazepines, such as lorazepam (Ativan) or diazepam (Valium).
2. Managing potential lethal overdose, including referral to specialist, methods to treat hyperthermia, restraints, pharmacologic management of uncontrolled hypertension by intravenous administration of phentolamine (Regitine) or dopamine (Intropin), and seizures with intravenous diazepam or other benzodiazepine.
3. Managing stimulant withdrawal: Pharmacologic treatment for agitation and insomnia, as needed, with trazodone (Desyrel). Benadryl is also used for its sedating properties and for its effects on the dermatologic problems that often accompany methamphetamine use.
4. Identification and management of medical complications such as cardiovascular and respiratory effects.
5. Identification and management of psychological complications such as toxic psychosis, drug sensitization, and aggression and violence.
6. Assessment and diagnosis using the following: Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV) criteria for amphetamine or cocaine use/abuse/dependence; substance abuse history; testing of stimulants in urine.

Managing Special Groups and Settings:

1. Training for counselors in cultural sensitivity.
2. Providing multi-component human immunodeficiency virus (HIV) prevention programs.
3. Training for counselors in sexual and social behaviors of gay men.
4. Using contingency management approaches for narcotic replacement treatment.
5. Coordinating care of clients with co-occurring psychiatric disorders.
6. Treating individuals in the criminal justice system.
7. Racial/ethnic treatment considerations.
8. Strategies for providing treatment services to rural populations.
9. Training counselors in the special needs of women and adolescents, including domestic issues, medical problems, child-care needs, academic performance, and so on. Considering gender-specific treatment groups and school-based clinics.

MAJOR OUTCOMES CONSIDERED

Treatment efficacy as evidenced by relapse, abstinence, and retention in treatment.

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

All Treatment Improvement Protocols (TIPs) are produced after a major literature search followed by a meta-analysis by skilled professionals on the contractor's staff. Then the research-based evidence is combined with whatever field-based experience is shared at the consensus panel.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The Consensus Panel's recommendations summarized below are based on both researched and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2).

Because of recent health care reforms, most individuals who seek help for stimulant dependence now receive treatment at structured outpatient treatment programs. Accordingly, the guideline document provides recommendations for treatment strategies and techniques that are most relevant to the treatment of stimulant-dependent patients in structured outpatient treatment programs. However, many, if not most, of these strategies and techniques can be integrated into other types of programs, regardless of the setting or therapeutic orientation.

Psychosocial Treatment Approaches

Psychosocial treatment approaches that incorporate well established psychological principles of learning are appropriate for and effective in treating stimulant users. In an effort to make these approaches consistently effective, the Consensus Panel recommends the use of carefully prepared treatment manuals to minimize differences among therapists (2). Treatment manuals increase the likelihood that therapists will deliver a uniform set of services to their clients. However, the therapist's clinical judgment and flexibility are extremely important to the treatment process.

The Consensus Panel recommends a contingency management approach for treating stimulant users (1). A particularly successful version is the community-reinforcement-plus-vouchers approach in which couples counseling, vocational training, and skills training are combined with rewards for negative drug tests (i.e., "clean" urinalysis results).

Relapse Prevention

Relapse prevention systematically teaches clients

- How to cope with substance craving

- Substance refusal assertiveness skills
- How seemingly irrelevant decisions may affect the probability of later substance use
- General coping and problem-solving skills
- How to apply strategies to prevent a full-blown relapse should an episode of substance use occur

The Consensus Panel recommends this approach for use with stimulant users (1).

Other Interventions With Supportive Research

Research indicates that the following may be appropriate interventions for stimulant users:

- Permitting women entering residential treatment to be accompanied by some or all of their children (1)
- Supportive-expressive psychotherapy (1)
- "Node-link mapping," which uses flowcharts and other methods to diagram relationships between clients' thoughts, actions, feelings, and substance use (1)

Other Models of Psychosocial Treatment

A number of other psychosocial models and approaches have been described, and some used widely, for the treatment of stimulant use disorders, including:

- Network therapy, in which clients receiving individual psychotherapy develop a network of stable, nonsubstance-abusing support persons, such as family, partners, and close friends (2)
- Acupuncture (2)
- Therapeutic communities (the most common type of long-term residential treatment) (1)

Maximizing Treatment Engagement

Make treatment accessible

To maximize treatment engagement, programs must make treatment accessible. Having treatment programs in areas convenient to clients is associated with lower attrition rates (1).

Treatment should be provided during the hours and on the days that are convenient for clients (2). Programs should be located near public transportation and in a part of town viewed as safe for evening visits (2).

Provide support for treatment participation

Address clients' concrete needs, including transportation, housing, and finances (1). Some logistical barriers can be overcome by onsite services, through agreements with subcontractors, or by referrals. These can include onsite child care services, referrals to temporary shelters, vouchers for lunches, targeted

financial assistance, assistance with paperwork regarding insurance, or filing for disability benefits (2).

Respond quickly and positively to initial telephone inquiries

Because ambivalence about treatment is common among treatment-seeking stimulant users, methods to "screen out" those who are "in denial" are counterproductive and impede treatment entry (2). The initial interview should be scheduled within 24 hours after the client initially contacts the program (2).

Assessments and Orientations

Keep initial assessments brief

Initial assessments should be brief, focused, and nonrepetitive (2).

Provide clear orientations

Individuals need a thorough, clear, and realistic orientation about stimulant use disorder treatment. Clients should acquire a good understanding about the treatment process, the rules of the treatment program, expectations about their participation, and what they can expect the program to do for them and in what time frame (2).

Offer clients options

Addiction treatment is more effective when a client chooses it from among alternatives than when it is assigned as the only option. Thus, it is important to provide clients with options and negotiate with them regarding the treatment approaches and strategies that are the most acceptable and promising (1).

Involve significant others

Whenever possible, family and significant others who support the treatment goals should be involved in the treatment process (2).

Convey empathetic concern

Counselors should be warm, friendly, engaging, empathetic, straightforward, and non-judgmental. Authoritarian and confrontational behavior by the staff can substantially increase the potential for violence (2).

Planning Treatment

To organize treatment strategies, it can be helpful to view the treatment process as consisting of:

- A treatment initiation period
- An abstinence attainment period
- An abstinence maintenance phase

- A long-term abstinence support plan

The Consensus Panel recommends treatment for 12 to 24 weeks followed by some type of support group participation (2).

Clients should have a written schedule of expected attendance they can keep and give to family members who may be involved in treatment. It does not appear appropriate to deliver these services on an ad hoc or as needed basis (2).

Initiating Treatment

The initial period of stimulant abstinence is characterized by symptoms of depression, difficulty concentrating, poor memory, irritability, fatigue, craving for cocaine/methamphetamine, and paranoia (especially for methamphetamine users). The duration of these symptoms varies; in general, symptoms typically last 3 to 5 days for cocaine users and 10 to 15 days for methamphetamine users (2).

The first several weeks of treatment have some relatively simple and straightforward priorities.

Establish treatment attendance

During the first 2 or 3 weeks, clients should be scheduled for multiple weekly visits, even if the visits are 30 minutes in duration or less (2).

Discontinue use of psychoactive substances and initiate urinalysis schedule

Immediately upon entering the treatment program, clients should be placed on a mandatory, vigilant, and frequent urine testing schedule. This schedule should continue throughout the treatment process, although the frequency of testing can be tapered as treatment progresses. Urine samples should be taken every 3 or 4 days so as not to exceed the sensitivity limits of standard laboratory testing methods (2). Participation in self-help groups should be strongly encouraged but not required.

Assess psychiatric comorbidity

During the initial 2 weeks of treatment, it is important to assess the possible existence of other psychiatric conditions and, if present, initiate appropriate treatment, including medication (2).

Assess stimulant-associated compulsive sexual behaviors

Research has revealed an association between stimulant use and a variety of compulsive sexual behaviors. These behaviors include promiscuous sex, acquired immunodeficiency syndrome (AIDS)-risky behaviors, compulsive masturbation, compulsive pornographic viewing, and homosexual behavior for otherwise heterosexual individuals. In order for treatment to be effective, these issues must be discussed openly and nonjudgmentally (2).

Remediate stimulant "withdrawal" symptoms

Remind clients that proper sleep and nutrition are necessary to allow the neurobiology of the brain to "recover." Giving them "permission" to sleep, eat, and gradually begin a program of exercise, can help establish some behaviors that will have long-term utility. These behaviors will help them begin to think more clearly and begin to feel some benefit from their initial efforts in treatment (1).

Initiating Abstinence

Establish structure and support. After the initial treatment engagement of 1 to 2 weeks, the focus is on the achievement of abstinence. Although there is no clear delineation between clients who are initiating abstinence and those maintaining abstinence, the initiating period occurs roughly from 2 to 6 weeks into treatment (2).

Establish structure and support

Short-term goals should be set immediately and should be reasonably achievable. One such goal is complete abstinence from all substances for 1 week (2).

Brief, frequent counseling sessions can reinforce the short-term goal of immediate abstinence and establish a therapeutic alliance between the client and counselor. Events of the past 24 hours are reviewed in each session and recommendations are provided for navigating the next 24 hours (2).

Address secondary drug use

For many clients, their secondary substance use may not have been associated with adverse consequences or compulsive use. As a result, such clients need help to identify the connections between the use of other substances and their stimulant addiction (2).

Clients should be encouraged to throw out all substance-related items (2). Family members, sober friends, or 12-Step sponsors should help with this task.

Initiate avoidance strategies

Clients must develop specific action plans to break contacts with dealers and other stimulant users and to avoid high-risk places that are strongly associated with stimulant use (2).

Provide client education

Educate clients about learning and conditioning factors associated with stimulant use and the impact of stimulants and other substances on the brain and behavior, such as cognitive impairments and forgetfulness (2).

Other steps to initiate abstinence include:

- Identify cues and triggers (2)

- Develop action plan for cues and triggers (2)
- Enlist family participation (2)
- Establish social support systems (2)
- Address stimulant abuse-associated compulsive sexual behaviors (2)

Respond to early slips

Early slips should not be considered tragic failures but rather simple mistakes. When slips occur, counselors can make a verbal or behavioral contract with clients regarding short-term achievable goals (2).

Maintaining Abstinence

Teach functional analysis of stimulant use

The core components of a functional analysis are:

- Teaching clients to examine the types of circumstances, situations, thoughts, and feelings that increase the likelihood that they will use stimulants
- Counseling clients to examine the positive, immediate, but short-term consequences of their stimulant use
- Encouraging clients to review the negative and often delayed consequences of their stimulant use (2)

Teach relapse prevention techniques

Relapse prevention techniques fall into the following categories:

- Psychoeducation about the relapse process and how to interrupt it
- Identification of high-risk situations and relapse warning signs
- Developing coping and stress management skills
- Enhancing self-efficacy in dealing with potential relapse situations
- Counteracting euphoric recall and the desire to test control over use
- Developing a balanced lifestyle including healthy leisure and recreation activities
- Responding safely to slips to avoid escalation into full-blown relapse
- Establishing behavioral accountability for slips and relapse via urine monitoring and/or Breathalyzer testing (2)

Enhance self-efficacy regarding high-risk situations

Once clients learn to identify, manage, and avoid high-risk situations, the counselor and client should try to determine if the client is confident in her ability to use those skills in the real world through role-playing and other therapeutic techniques (2).

Counteract euphoric recall and desire to test control

So-called "war stories" that include euphoric recall and selective memory are powerful relapse triggers and should be strongly discouraged in recovery groups (2).

Medical Aspects

The following recommendations are for medical personnel to help them recognize and treat problems that may arise for stimulant users with acute or chronic intoxication or in various phases of withdrawal.

The most common reasons for emergency room visits by cocaine users are cardiopulmonary symptoms (usually chest pains or palpitations); psychiatric complaints, ranging from altered mental states to suicidal ideation; and neurological problems, including seizures and delirium.

The major presenting symptoms for methamphetamine users pertain primarily to altered mental status, including confusion, delusions, paranoid reactions, hallucinations, and suicidal ideation. The rapid development of tolerance to its physiological effects among chronic methamphetamine users may explain the relative infrequency of cardiac complications in this group (1).

The lethal dose of cocaine for 50 percent of novice users (LD50) is 1.5 grams. The LD50 for methamphetamine has not specifically been established, and there is significant individual variability to its toxicity. For example, doses of 30 milligrams can produce severe reactions, yet doses of 400 to 500 milligrams are not necessarily fatal (1).

Management of stimulant intoxication

Uncomplicated intoxication requires only observation and monitoring in a subdued environment until symptoms subside over several hours.

Physical exertion and an overheated room can potentiate adverse effects because stimulants affect the body's heat-regulating mechanism at the same time that blood vessel constriction conserves heat.

Indications that agitation is escalating and moving toward paranoia and potential psychosis (losing touch with reality), with increasing risk for violence, may warrant pharmacological intervention. Fast-acting benzodiazepines such as lorazepam (Ativan) or diazepam (Valium) are useful for calming an anxious, agitated client (1).

Management of potentially lethal overdose

- Manage hyperthermia by sedating to slow down and stop agitated movements and by rapidly cooling the client with body ice packs, mist and fan techniques, or cooling blankets (1).
- If restraints are required to start an intravenous administration, use mesh-type blankets only transiently to avoid interfering further with heat loss (2).
- Uncontrolled hypertension can be managed by intravenous administration of phentolamine (Regitine) or dopamine (Intropin) (1).
- Treat seizures like status epilepticus with intravenous diazepam or other benzodiazepine. Diazepam is most effective if administered before or shortly after cocaine ingestion but is less effective after seizures begin (1).

Management of stimulant withdrawal

The greatest risk from the distinctive stimulant abstinence syndrome is that one may do harm to oneself or others. Because withdrawal-related dysphoria and depression can be particularly severe in stimulant users, risk of suicide is intensified, and sensitive management is essential (1, 2).

Continuing agitation and persistent inability to fall asleep during withdrawal may also be treated symptomatically by using the antidepressant trazodone (Desyrel). Diphenhydramine (Benadryl) can also be used for its sedating properties (1, 2).

Common physiological symptoms of chronic stimulant abuse/dependence

- Extreme fatigue--with physical and mental exhaustion and disrupted sleep patterns
- Nutritional disorders--extreme weight loss, anemia, anorexia, cachexia (body wasting)
- Poor hygiene and self-care
- Skin disorders and secondary skin infections--itching, lesions, hives, urticaria
- Hair loss
- Muscle pain/tenderness--may indicate rhabdomyolysis
- Cardiovascular damage--from toxicity and contaminants in methamphetamine production, with concomitant renal and hepatic problems
- Hypertensive crises with renal damage from sustained hypertension
- Difficulty breathing--may reflect pulmonary edema, pneumonitis, obstructive airway disease, barotrauma, and other complications
- Myocarditis, infarcts
- Headaches, strokes, seizures, vision loss
- Choreoathetoid (involuntary movement) disorders
- Impaired sexual performance and reproductive functioning
- Cerebrovascular changes, including evidence of cerebral hemorrhages and atrophy with associated cognitive deficits
- Ischemic bowel, gastrointestinal complaints

Common psychological/behavioral symptoms of chronic stimulant abuse/dependence

- Paranoia--with misinterpretation of environmental cues; psychosis with delusions, and hallucinations
- Apprehension--with hopelessness and fear of impending doom that resembles a panic disorder
- Depression--with suicidal thinking and behavior
- Acute anxiety
- Eating disorders

Distinctive indicators of chronic stimulant abuse/dependence

- Nasal perforations and nose bleeds among snorters
- Dental problems, including missing teeth, bleeding and infected gums, dental caries
- Muscle cramping related to dehydration with low magnesium and potassium levels

- Dermatitis around the mouth from smoking hydrochloride salt
- Stale urine smell due to ammonia constituents used in manufacturing methamphetamine
- Various dermatologic conditions, including excoriated skin lesions
- Serious constipation due to dehydration and insufficient dietary fiber

Reducing the risk of violence

Medical personnel must be prepared for the paranoia, aggression, and violence that often accompany stimulant use. These personnel should:

- Keep the client in touch with reality by identifying themselves, using the client's name, and anticipating his concerns (2).
- Place the client in a quiet, subdued environment with only moderate stimuli. Ensure sufficient space so that the client does not feel confined. Have the door readily accessible to both the client and the interviewer, but do not let the client get between the interviewer and the door (2).
- Acknowledge agitation and potential for escalation into violence by reassuring the client that they are aware of his distress; asking clear, simple questions; tolerating repetitive replies; and remaining nonconfrontational (2).
- Foster confidence by listening carefully, remaining nonjudgmental, and reinforcing any progress made (2).
- Reduce risk by removing objects from the room that could be used as weapons and discreetly ensuring that the client has no weapons (2).
- Be prepared to show force if necessary by having a backup plan for help and having chemical and physical restraints immediately available (2).
- Train all medical or emergency staff to work as a team in managing volatile clients (2).

There are a number of medical and psychiatric disorders that frequently accompany stimulant abuse and dependence. An awareness of these conditions is important for the safe and effective treatment of stimulant disorders. The conditions include:

- Cardiovascular system effects
- Respiratory-pulmonary effects
- Cerebrovascular complications
- Muscular and renal toxicity
- Gastrointestinal complaints
- Infections
- Effects on reproduction/formation of fetus/newborn children
- Human immunodeficiency virus (HIV), AIDS, and hepatitis
- Toxic psychosis
- Aggression and violence
- Polysubstance abuse
- Traumatic injury

Assessment and diagnosis

A diagnosis can be based on established Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV) criteria for amphetamine or cocaine use/abuse/dependence and other listed composites (1).

An appropriate substance use history should include the substance(s) and medications used during the last 30 days; the specific substance(s) or combinations typically used with the usual dose, frequency, and route of administration; the duration of use/abuse; and the time and amount of last use as well as when the symptoms or complaints developed and how they have progressed (2).

Stimulants typically can be detected in urine for approximately 24 to 48 hours following use and, maximally, for 3 days.

Special Groups and Settings

The Consensus Panel feels strongly that cultural competence in treatment extends beyond racial/ethnic sensitivity to understanding the mores of groups bound together by gender, age, geography, sexual preferences, criminal activity, substance use, and medical and mental illnesses. The Consensus Panel therefore recommends the following:

- Counselors should be trained in cultural sensitivity and cultural competency issues to enhance the counselor's understanding and appreciation of both the client's background and his needs within that context (1, 2).
- Intravenous drug users should have access to multicomponent HIV prevention programs, which include instruction on bleach disinfection along with skills training, counseling, and HIV testing. Needle exchange programs may also be helpful (1, 2).
- For counselors working with gay men, education of the sexual and social behaviors that are common among this population (including the widespread use of methamphetamine), as well as the stigma associated with substance abuse in the gay community, should be available (2).
- For clients in narcotic replacement treatment, including methadone and LAAM, cocaine use is a major clinical problem. The most effective method of addressing this particular community appears to be contingency management approaches (2).
- Clients with co-occurring psychiatric disorders have high levels of stimulant abuse and dependence. Successful treatment of these individuals requires close coordination of psychiatric and stimulant use disorder treatments (2).
- Treatment for individuals in the criminal justice system is a rapidly expanding area of need. Stimulant users represent a substantial portion of the individuals in the court and prison treatment population (2).
- For rural populations, forming linkages between social service agencies, providing treatment services that are flexible in scope and structure, and using nontraditional outreach sites such as mobile or satellite offices are all important interventions (2).
- Counselors should be aware of the special needs of women and adolescents, including domestic issues, medical problems, child care needs, academic performance, and so on. Gender-specific treatment groups and school-based clinics can be helpful in reaching these particular groups (1, 2).

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved treatment outcomes for stimulant abuse and dependence.

POTENTIAL HARMS

- The greatest risk from the distinctive stimulant abstinence syndrome is that one may do harm to oneself or others. Because withdrawal-related dysphoria and depression can be particularly severe in stimulant users, risk of suicide is intensified, and sensitive management is essential.
- Additional withdrawal-related symptoms also include agitation and persistent inability to fall asleep.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services. No official support or endorsement of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, or the Department of Health and Human Services for these opinions or for particular instruments or software that may be described in the original guideline document is intended or should be inferred. The guidelines proffered in the original guideline document should not be considered as substitutes for individualized client care and treatment decisions.
- Almost all of the information has been gleaned from studies conducted with cocaine users. Similar studies with methamphetamine users have not been reported. However, evidence from at least one study indicates that cocaine and methamphetamine users respond similarly to psychosocial interventions, suggesting that what has been learned from cocaine users may be applicable to methamphetamine users.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols are distributed to facilities and individuals across the country.

The original Treatment Improvement Protocol document includes resources to help providers implement the recommendations in the Treatment Improvement Protocol.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Treatment Improvement Protocol (TIP) Series 33 Consensus Panel. Treatment for stimulant use disorders. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 33). [317 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

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GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 33 Consensus Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Consensus Panel Members: Richard A. Rawson, Ph.D., Panel Chair; Felipe G. Castro, M.S.W., Ph.D., Workgroup Leader; James W. Cornish, M.D., Workgroup Leader; Frances R. Levin, M.D., Workgroup Leader; Michael J. McCann, M.A., Workgroup Leader; Panelists: Arlene Hall, R.N., M.S., C.D.; Stephen Higgins, Ph.D.; Kyle M. Kampman, M.D.; Quintin Kingfisher; Judy Knobbe, M.S.W., L.I.S.W., C.A.D.C.; Wendy Lay; Scott M. Reiner, M.S., C.A.C., C.C.S.; Ewa Szumotalska Stamper, Ph.D.; Arnold M. Washton, Ph.D.; Dennis A. Weis, M.D.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 18, 2000. It was verified by the guideline developer as of January 25, 2001.

Date Modified: 4/12/2004